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*Session: Antibiotic Resistance: National Actions Contribute to a Global Solution**Date: Thursday, March 3, 2016**Time: 15:45–17:45**Room: Hall 1***South Africa's perspective on antibiotic resistance**M. Mendelson^{1,*}, P. Matsoso^{2,*}¹ University of Cape Town, Cape Town, South Africa² National Department of Health, Pretoria, South Africa**Abstract:** (no abstract received from presenter)<http://dx.doi.org/10.1016/j.ijid.2016.02.053>**Type: Invited Presentation**

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*Session: Antibiotic Resistance: National Actions Contribute to a Global Solution**Date: Thursday, March 3, 2016**Time: 15:45–17:45**Room: Hall 1***Kenya's perspective on antibiotic resistance**G. Revathi^{1,*}, C. Mailu^{2,*}¹ Aga Khan University Hospital, Nairobi, Kenya² Ministry of Health, Nairobi, Kenya

Abstract: History of AMR surveillance in Kenya goes back to late 1970s and early 80s when Kenyatta National Hospital and University of Nairobi, College of Health Sciences began compiling and following antibiotic susceptibility patterns of routine clinical isolates. 5th ICID held in Nairobi in 1992 gave birth to ICAK (infection Control Association of Kenya) composed of pathologists, pharmacologists and nurses. Hospitals appointed IPC committees around the same time under WHO guidance. Lab based AMR surveillance was an IPC activity at that time. Except the national referral hospital and a few small private hospitals in Nairobi, hospitals cannot generate AMR data due to absence of microbiology labs. Almost all AMR data is generated by scientists of Kenya Medical Research Institute or other externally funded international research groups. Most of these projects focus on organism based AMR since they are proposed by scientists. There are no updates on AMR in clinical conditions like meningitis, pneumonia or bacteremia in the community due to lack of local funding support. Recognition of diagnostic laboratory capacity as an essential component of health care system for effective disease surveillance and control- was still lacking at national level until the release of WHO white paper in 2008 declaring public health labs in Africa a top priority for funding. World Bank sponsored East African Public Health Laboratory Network (EAPHLN) Project covering Kenya, Tanzania, Uganda and Rwanda; ASM and CDC supported Lab Cap program are two bright examples. The Launch of GARP Kenya project in 2009 and compilation of situation analysis in 2011 are important mile stones since this project brought together various professionals across the

country and establishment of AMR focal person and IPC secretariat in the Ministry of Health. World health assembly resolution on AMR in 2014 paved way to development of W H O global action plan on AMR in 2015 which urged member states to make National action plans for dealing with AMR. Kenya is well prepared to face the challenge of AMR. EAPH Lab network is able to provide the infrastructure for AMR surveillance. Close partnerships between technical and clinical professionals and strong financial support from Local and National health care managers are crucial.

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*Session: Antibiotic Resistance: National Actions Contribute to a Global Solution**Date: Thursday, March 3, 2016**Time: 15:45–17:45**Room: Hall 1***Nepal's perspective on antibiotic resistance**R. Chaudhary^{1,*}, P.K. Pokharel^{2,*}¹ Ministry of Health, Kathmandu, Nepal² B.P. Koirala Institute of Health Sciences, Dharan, Nepal**Abstract:** (no abstract received from presenter)<http://dx.doi.org/10.1016/j.ijid.2016.02.055>**Type: Invited Presentation**

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*Session: Antibiotic Resistance: National Actions Contribute to a Global Solution**Date: Thursday, March 3, 2016**Time: 15:45–17:45**Room: Hall 1***Mozambique's perspective on antibiotic resistance**B. Sigauque^{1,*}, M. Saide^{2,*}¹ GARP, Maputo, Mozambique² Ministry of Health Mozambique, Maputo, Mozambique

Abstract: For the last two decades, health has been a high priority in Mozambique. Although antibiotic resistance was not a major focus, many of the measures taken, by the Mozambique government, will have helped preserve the effectiveness of antibiotics. These include reducing the burden of infectious disease by introducing new vaccines in the national immunization program, building health infrastructure in rural settings, increasing the paramedical and medical workforce at the district level, deploying community health workers in remote underserved settings, adopting Integrated Management of Childhood Illness (IMCI) in basic health facilities and encouraging the establishment of private pharmacies in the rural areas where most of the population lives. Mozambique was early among African countries to begin hospital infection control and prevention programs and to monitor hospital-acquired infections. Recognizing the problem of drug quality in